Background Information about the Multilingual Hawaii Advance Directive

The Hawaii Advance Health Care Directive (HI AD) or ‘Advance Directive’ (AD) as it is commonly known, is a written statement about your future medical care. Starting May 2016 the HI AD is available in 10 languages. To facilitate the discussion for providers and loved ones, the HI AD is a bilingual document translated content block by content block.

Please keep in mind that most providers speak English only. To ensure that your wishes and instructions are understood and can be honored, please fill out your HI AD in English. In order to complete an advance directive you need to either have two witnesses or a notary public for it to be valid.

Important limitation: If you choose to complete the English portion of a bilingual HI AD, State of Hawaii regulations require a bilingual Notary to notarize your bilingual version of the advance directive.

“The notarization of a document that has been written in a foreign language should only be performed by a notary who has a thorough understanding of the foreign language in which the document and/or notarial certificate are written.” [..] Similarly, a notary should not notarize a document written in English if the parties to the document who appear before the notary do not appear to speak, read, or understand English.” Page 5, Notary Manual 2010.

Call the Notary Public Program (808) 586-1216 for a bilingual notary, or go to their website https://notary.ehawaii.gov/notary/public/publicsearch.html (‘Search Category’: choose ‘Language’ in the fold down menu and in ‘Search Terms’ type in the language you want).

Please call the notary public office if you have more questions regarding using a bilingual notary.

Two recommendations for completing your bilingual AD:

1) Use **two witnesses** to complete a bilingual HI AD. Witnesses cannot be health care providers (like a doctor, nurse or social worker), employees of a health care facility, or the person you choose as an agent. One of the two persons cannot be related to you or have inheritance rights.

OR

2) Use a **bilingual notary**.
This page is left intentionally blank
HAWAI‘I ADVANCE HEALTH CARE DIRECTIVE

My name is:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle initial</th>
<th>Date of Birth</th>
<th>Date</th>
</tr>
</thead>
</table>

PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT:
I designate the following individual as my agent to make health care decisions for me:

Name and relationship of individual designated as health care agent

Street Address

City

State

Zip

Home Phone

Cell Phone

E-mail

If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

Name and relationship of individual designated as health care agent

Street Address

City

State

Zip

Home Phone

Cell Phone

E-mail

AGENT’S AUTHORITY AND OBLIGATION:
My healthcare agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE:
My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

☐ If I mark this box, my agent’s authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care. I can revoke this authority at any time as long as I have mental capacity.

PAKAUNA A BILIN MAINAIG ITI PANNAKATARIPATO TI SALUN-AT ITI HAWAI‘I

Siak ni:

<table>
<thead>
<tr>
<th>Apelyido</th>
<th>Nagan</th>
<th>Middle initial</th>
<th>Petsa ti Pannakayanak</th>
<th>Petsa</th>
</tr>
</thead>
</table>

PASET 1: HEALTH CARE POWER OF ATTORNEY – PANANGDUTOK ITI AHENTE:
Dutokak ti sumaganad a tao kas ahentek nga agaramid kadagit desision mainaig iti pannakataripato ti salun-at para kaniak:

Nagan

ken pakainaan iti tao a nadutokan kas ahente iti pannakataripato ti salun-at

Address ti Kalsada

Siudad

Estado

Zip

Telepono iti Balay

Cell Phone

E-mail
I want to stop or withhold medical treatment that would prolong my life.

OR

I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

THEN I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: Check only one of the following boxes. You may also initial your selection.

- [ ] I want to stop or withhold medical treatment that would prolong my life.
- [ ] I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.
__ □ Kayatko a maisardeng wenno saan a maipaay ti medikal a panagagas a mangpaatiddog iti biagko.

**WENNO**

__ □ Kayatko ti medikal a panagagas a mangpaatiddog iti biagko agpatingga iti mabalìn iti las-ud
dagiti limitasion dagiti pagibatayan ti pannakataripato ti salun-at nga akseptaren ti sapasap.

**B. ARTIFICIAL NUTRITION AND HYDRATION - FOOD AND FLUIDS:**

Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice
I have made in the preceding paragraph A unless I mark the following box.

__ □ If I mark this box, artificial nutrition and hydration must be provided under all circumstances as
long as it is within the limits of generally accepted healthcare standards.

__ □ If I mark this box, the additional instructions or information I have attached are to be incorporat-
ed into my care. (Sign and date each added page and attach to this form.)

**C. RELIEF FROM PAIN:**

__ □ If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

**C. GIN-AWA MANIPUD ITI SAKIT WENNO OT-OT:**

__ □ No markaak daytoy a kahon, piliek ti panagagas tapno mabang-aran ti sakit/ot-ot wenno kina-awan
gin-awa uray pay no padarasenna ti ipupusayko.

**D. OTHER**

__ □ If I mark this box, the additional instructions or information I have attached are to be incorporat-
ed into my care. (Sign and date each added page and attach to this form.)

**D. DADDUMA PAY**

__ □ No markaak daytoy a kahon, maitipon iti pannakataripatok dagiti nayon nga instruksion wenno
impormasion nga insigpitko. (Pirmaan ken ikkan ti petsa ti tunggal panid ken isigpit iti daytoy a
pormas.)

**E. WHAT IS IMPORTANT TO ME:** (Optional. Add additional sheets if needed.) The things that I
value and that make life worth living to me are: (examples: gardening, walking my pet, shopping, partici-
pating in family gatherings, attending church or temple):

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

__ □ I have attached ____ additional sheet/s
E. ANIA TI IMPORTANT KANIAK: (Saan nga inkapilitan. Agusar iti sabali pay a papel no kasapulan.)
Dagiti banbanag a tagipatgek ken gapuanan tapno adda pay la anag ti panagbiagko ket: (kas pangarigan: panagtaripato iti mulmula, panangipapagna iti asok, panag-shopping, pannakipaset kadagiti panagsasarak ti pamilia, ipapan iti simbaan wenno templo):

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

□ Nangisigpitak iti _____ a nayon a papel/es

My thoughts about when I would not want my life prolonged by medical treatment (Examples include: If I no longer have the mental capacity to make my own decisions, if I have lost all ability to communicate, if I can no longer safely swallow, etc):

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

□ I have attached _____ additional sheet/s

Dagiti kapanunotak maipanggep no kaano a saanko kayat a maiyat-atiddog ti biagko babaen iti medikal a panagagas (Mairaman kas pangarigan dagiti: No awanen ti nasimbeng a panunotko nga agaramid kadagiti bukodko a desision, no napukawkon ti kabaetak a makipatang, wenno saannakon a makatilmon a natalged, kdpy):

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

□ Nangisigpitak iti _____ a nayon a papel/es

Iburay ken patangenyo iti doktoryo, kadagiti ipatpategyo ken iti ahenteyo ti maipanggep iti
Pakauna a Bilinyo mainaig iti Pannakataripato ti Salun-at

Panid 4 ti 7
YOUR NAME: (Please sign in front of witnesses or notary public)

<table>
<thead>
<tr>
<th>Print Your Full Name</th>
<th>Your Signature</th>
<th>Date of Birth</th>
<th>Date</th>
</tr>
</thead>
</table>

TI NAGANYO: (Agpirma kayo koma iti imatang dagiti saksi wenno notario publiko)

<table>
<thead>
<tr>
<th>I-print ti Kumpleto a Naganyo</th>
<th>Ti Pirmayo</th>
<th>Petsa ti Pannakayanak</th>
<th>Petsa</th>
</tr>
</thead>
</table>

WITNESSES: CHOOSE EITHER OPTION 1 OR 2, NOT BOTH.

Important: Witnesses cannot be your health care agent, a health care provider or an employee of a health care facility. One witness cannot be a relative or have inheritance rights.

OPTION 1: WITNESSES

I (Witness 1) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not related by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of her/his estate. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

<table>
<thead>
<tr>
<th>Witness #1 Print Name</th>
<th>Witness Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State Zip</td>
</tr>
</tbody>
</table>

DAGITI SAKSI: PILIEN TI MAYSA LAENG KADAGITI PAGPILIAN 1 WENNO 2, SAAN NGA ISUDA A DUA.

Importantte: Dagiti saksi ket saan a mabalin nga ti ahente iti pannakataripato ti salun-atyo, mangipapaay iti pannakataripato ti salun-at wenno empleado ti pasilidad a pakataripatoan ti salun-at. Ti maysa kadagiti saksi ket saan a mabalin a kabaggianyo wenno agtawid kadakayoy.

PAGPILIAN 1: DAGITI SAKSI

Ipablaakko (Saksi 1) a ti tao a mangkumkumpleto iti daytoy a pakauna a bilin mainaig iti pannakataripato ti salun-at ket personal nga am-ammok, a pinirmaan wenno inaklonna daytoy a power of attorney iti imatangko ken kasla met nasimbeng ti panunotna ken awan ti nangpilhit kenkuana. Awan ti pakainaigak kenkuana babaen panagkabaggian, panagasawa, wenno panagadaptar, ken iti pagpatinggaan ti ammok awan ti karbengak iti aniamaan a paset ti sanikuana. Saan a siak ti tao a nadutokan kas ahente iti daytoy a dokumento, ken saan a siak ti mangipapaay ti pannakataripato ti salun-at, ken saanak nga empleado ti mangipapaay ti pannakataripato ti salun-at wenno ti pasilidad a pakataripatoan ti salun-at.

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<thead>
<tr>
<th>Saksi #1 I-print ti Nagan</th>
<th>Pirma ti Saksi</th>
<th>Petsa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address ti Kalsada</td>
<td>Siudad</td>
<td>Estado Zip</td>
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</tbody>
</table>

Iburay ken patangenyo iti doktoryo, kadagiti ipatpategyo ken iti ahenteyo ti maipanggep iti
Pakauna a Bilinyo mainaig iti Pannakataripato ti Salun-at

Panid 5 ti 7
I (Witness 2) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

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<tr>
<th>Witness #2 Print Name</th>
<th>Witness Signature</th>
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Ipablaakko (Saksi 2) a ti tao a mangkumkumpleto iti daytoy a pakauna a bilin mainaig iti pannakataripato ti salun-at ket personal nga am-ammok, a pinirmaan wenno inaklonna daytoy a power of attorney iti imatangko ken kasla met nasimbeng ti panunotna ken awan ti nangpilit kenkuana. Saan a siak ti tao a nadutokan kas ahente iti daytoy a dokumento, ken saan a siak ti mangipapaay ti pannakataripato ti salun-at, ken saanak nga empleado ti mangipapaay ti pannakataripato ti salun-at wenno ti pasilidad a pakataripatoan ti salun-at.

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<th>Saksi #2 I-print ti Nagan</th>
<th>Pirma ti Saksi</th>
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OPTION 2: NOTARY PUBLIC

State Hawai‘i, (City and) County of ____________________________

On this ______ day of ____________________, in the year _______________, before me, ____________________________________________, (insert name of notary public) appeared ___________________________________________, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this ___ -page Hawai‘i Advance Health Care Directive dated on ___________________, in the _________________ Judicial Circuit of the State of Hawai‘i, and acknowledged that he/she executed the same as his/her free act and deed.

<table>
<thead>
<tr>
<th>Signature of Notary Public</th>
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<td></td>
</tr>
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</table>

<table>
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<tr>
<th>My Commission Expires: ____________________</th>
</tr>
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</table>

Place Notary Seal or Stamp Above

A copy has the same effect as the original.

www.kokuamau.org/resources/advance-directives

Developed by the Executive Office on Aging and Kokua Mau - Hawaii Hospice and Palliative Care Organization

December 2015
PAGPILIAN 2: NOTARIO PUBLIKO

Iti daytoy nga __________ aldaw ti ________________, iti tawen nga ________________, iti imatangko, ____________________________________________________________, (ikabil ti nagan ti notario publiko) immay ni ____________________________________________________________, personal nga am-ammok (wenno pinanekekanna ti kiniasisinona babaen iti makapnek nga ebdensia) nga isuna ti tao a nainaganan iti daytoy ___ -panid a Pakauna a Bilin mainaig iti Pannakataripato ti Salun-at iti Hawai’i a napetsaan idi ________________, iti ________________Judicial Circuit ti Estado ti Hawai’i, ken inaklonna nga isuna ti nangipatungpal iti daytoy kas nawaya a ganuat ken aramid.

__________________________
Pirma ti Notario Publiko

Ti Komisionko ket Agpatingga no: ___________________

Ti kopya ket addaan iti bileg a kas met la iti orihinal.
www.kokuamau.org/resources/advance-directives
Inaramid ti Executive Office on Aging and Kökua Mau - Hawai’i Hospice and Palliative Care Organization

Enero 2016